DD-163-PF (5-07)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

Clear The Form

GENERAL CONSENT AND AUTHORIZATION

I, _____ , certify that I am the
(Full name of the legally responsible person)

_____ of _____
(Relationship to the client) *(Full name of client)*

and I consent to the following for ☐ him/☐ her for a period not to exceed 12 months from the date of my signature below:
(Check (x) and initial all that apply)

☐ Yes ☐ No _____ Necessary emergency treatment(s).

☐ Yes ☐ No _____ Routine medical care.

☐ Yes ☐ No _____ Routine dental care.

☐ Yes ☐ No _____ Use of sedation/restraint when prescribed by a physician for medical/dental purposes.

☐ Yes ☐ No _____ Necessary educational, vocational, and therapeutic evaluations/assessments with the exception(s) of:

_____

☐ Yes ☐ No _____ Participation in routine recreational/leisure activities.

☐ Yes ☐ No _____ Administration of over-the-counter medicines and ongoing medications *(prescribed by a physician or dentist and not to exceed the maximum dosage)*, except for:

_____

Release of the following information checked (x) "yes":

☐ Yes ☐ No _____ Medical records

☐ Yes ☐ No _____ Educational

☐ Yes ☐ No _____ Social

☐ Yes ☐ No _____ Psychological

☐ Yes ☐ No _____ Financial

☐ Yes ☐ No _____ Other _____

For those categories where I have checked "No", my signature is required prior to the occurrence of such events or the release of any information.

The preceding has been explained to me and I certify that I understand it fully. I also understand that my consent may be withdrawn at any time by my written notification to the Department of Economic Security, Division of Developmental Disabilities.

_____ _____
(Client's signature – if applicable) *(Date)*

_____ _____
(Responsible person's signature) *(Date)*

_____ _____
(DDD case manager/designee's signature) *(Date)*

_____
(Print DDD case manager/designee's name and title)

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